Chapter 4

Sexual and gender minorities: consideration for therapy and training

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> Alice could not help her lips curling in a smile as she began, 'Do you know. I always thought Unicorns were fabulous monsters too! I never saw one alive before!' 'Well, now that we have seen each other', said the Unicorn, 'If you'll believe in me, I'll believe in you. Is that a bargain?' 'Yes, if you like', said Alice.
>
> Lewis Carroll

Lesbian and gay men are frequent users of therapy (Bieschke *et al.*, 2000) and transsexual clients need to see a therapist as a requirement to gain access to gender reassignment treatments, as well as for numerous other reasons (Hovell & Davidson, in press). However, training in issues relevant to lesbian, gay, bisexual or transsexual (LGBT) people, and guidance on how to work with them in a respectful and enabling way, is only now beginning to develop within psychology, counselling and psychotherapy (Shaw *et al.*, 2008). In addition to this, even less is written or researched into heterosexual sexuality (with the exception of Denman, 2004) as the dominant sexual group, which remains predominantly uncritiqued or explored. Within this group, gender roles are taken as fixed and stable (discussed in depth in chapter 1) and so therapists rarely think about those who fall outside these dominant heterosexual or gender norms.

Census data suggests that 6 per cent of the UK population identify as lesbian or gay (Department of Trade and Industry, 2006), which equates to 3.6 million people. This figure does not include those who identify as bisexual or who may have same-sex sexual experiences but identify as heterosexual. It also does not include transgender people who may not classify themselves within male and female, and so may not fall within the category of 'heterosexual', sometimes preferring the label 'queer'. This chapter will focus on sexual and gender minority identities, providing useful information that can be used in teaching or with clients, as well as self-reflective exercises to develop one's understanding and practice.

The chapter begins with exploring the contexts that influence LGBT lives, before moving on to discuss therapy specific topics. This broad introductory

stance is taken because it is essential that therapists have explored their own beliefs, attitudes and feelings about sexuality and expectations of gender before working with LGBT clients (Godfrey *et al.*, 2006). This self-reflection applies to both heterosexual and non-transsexual therapists in order to work 'cross-culturally' (as with working across race, religion, gender etc.), as well as LGBT identified therapists to avoid assumptions of knowledge or similarity. Roberts (2005) proposed that such self-reflection is essential to address the power differentials within the therapeutic relationship and the potential positions of privilege or oppression in the lives of therapist and client.

The topics in this chapter reflect those suggested for training about sexual and gender minority issues as recommended by the British Psychological Society (BPS) Division of Clinical Psychology (2007):

- addressing attitudes and myth busting;
- heterosexism and homophobia/biphobia/transphobia;
- therapies aimed at changing sexual orientation/conversion therapies;
- theories of sexuality and transgender;
- working with LGBT clients;
- sexual and gender minority therapy;
- legislation;
- issues for LGBT therapists;
- useful resources.

ADDRESSING ATTITUDES AND MYTH BUSTING

As mentioned previously, before working with LGBT clients it is important to have explored one's own attitudes and beliefs about sexuality and gender. Based on the premise that 'prejudiced attitudes are grounded in misinformation' (Peel, 2002: 259), it is hoped that by 'exposure to realities of lesbian and gay lives, people's prejudices and fears can be overcome' (Peel, 2002: 255).

Experiential exercises are a useful way to put oneself in the shoes of the 'other', to move beyond abstract conceptualisations of what this would be like and instead engage participants' emotions as to what it would *feel* like. Such exercises encourage individualised active learning, where the participant is struck by points that are pertinent to them. 'Homoworld' and 'The Heterosexual Questionnaire', described below, provide useful tools for therapists or trainers to self-reflect and draw out their attitudes and beliefs about LGB lives for examination.

Homoworld

Homoworld (Butler, 2004) is written as a day-in-the-life story about a heterosexual who lives in a world where the majority of people are lesbian or gay. While reading or listening, the following questions could be considered as a guide.

- What surprised or struck you?
- Did anything make you feel uncomfortable?
- What forms of support might you have employed?
- What issues did it reveal to you that people from sexual minorities may face (emotionally, socially, politically)?
- What issues did it bring up regarding sexuality generally?

Homoworld is provided in Appendix 1 of this chapter. It has also been adapted into a film and is available free of charge from the Doctorate in Clinical Psychology at the University of East London, London.

The Heterosexual Questionnaire

This questionnaire was developed by Rochlin (1992) and asks questions to heterosexual people that are often asked to LGB people. Readers can thus experience what emotions it raises to be asked these questions and if any questions seem particularly absurd or intrusive.

The Heterosexual Questionnaire

1 What do you think caused your heterosexuality?
2 When and how did you first decide that you were heterosexual?
3 Is it possible that your heterosexuality stems from a neurotic fear of members of the same sex?
4 Isn't it possible that all you need is a good gay lover?
5 If heterosexuality is normal, why are a disproportionate number of mental patients heterosexual?
6 Who have you disclosed your heterosexuality to? How did they react?
7 The great majority of child molesters are heterosexuals (95 per cent). Do you really consider it safe to expose your children to heterosexual teachers?
8 Heterosexuals are noted for assigning themselves and each other to narrowly restricted, stereotyped sex roles. Why do you cling to such an unhealthy form of role playing?
9 Why do heterosexuals place so much emphasis on sex?
10 There seem to be very few happy heterosexuals. Techniques have been developed that you might be able to use to change your sexual

orientation. Have you considered aversion therapy to treat your sexual orientation?

11 Why are heterosexuals so promiscuous?
12 Why do you make a point of attributing heterosexuality to famous people? Is it to justify your own heterosexuality?
13 If you've never slept with a person of the same sex, how do you know you wouldn't prefer that?
14 Why do you insist on being so obvious and making a public spectacle of your heterosexuality? Can't you just be what you are and keep it quiet?

Source: Rochlin, M. (1992). In W.J. Blumenfeld (ed.), *Homophobia: How we all pay the price*. Copyright © 1992 Warren J. Blumenfeld. Reproduced with permission of Beacon Press, Boston.

Challenging, and hopefully changing, negative attitudes can also sometimes require the direct provision of alternative accurate information to dispel negative beliefs and stereotypes. The follow sections provide useful information and resources to address such a challenge.

Heterosexual/gender privilege

Heterosexual/gender privilege refers to things that heterosexual or non-trans people might take for granted, but which are actually awarded them because of their heterosexuality or non-trans status. Examples include:

- seeing yourself represented in advertising as a model of 'normality';
- knowing that your sexuality or gender will be unquestioned, accepted and will not raise any eyebrows, or worse, provoke hostility;
- not having to think twice about talking about your partner;
- being comfortable with your gender of birth;
- having a developmental and established sense of your 'performance' of your gender (e.g. fashion, gesture, etc.).

Are there other examples that you could think of? If this exercise is used in training it can provide an opportunity to give an update on how things have changed in more recent years (for example, same-sex couples can now adopt (Adoption and Children Act, 2002), same-sex partnerships can now be legally recognised (Civil Partnership Act, 2005), you can change your gender on your birth certificate (Gender Recognition Act, 2004) etc.).

The use of films

Films provide a gentle way of challenging negative stereotypes if chosen carefully. A list of suggested films is provided in Appendix 2. Film clips can

be used in training as a way of emphasising prejudice depicted in the film, which can also lead onto a discussion of how things may have moved on.

Quiz

The quiz below is one way to test your knowledge and beliefs about LGBT issues. If you are using such a quiz in training, participants can keep their answers to themselves to avoid any pressures of being seen as not knowing in the wider group.

Questions

1 What is the age of consent for lesbians?
2 What percentage of LGBT people have children?
3 How many homosexuals are estimated to have died in Nazi concentration camps during World War II?
4 In what year was gay male sex no longer criminalised?
5 In what year was homosexuality no longer considered a mental illness?
6 What was Section 28?
7 Under the Gender Recognition Act (2004) what criteria must someone meet to have his or her acquired gender legally recognised?

Answers

1 There isn't one! The age of consent for gay men and heterosexual men and women is 16 since 2001.
2 Thirteen per cent of gay, bisexual and transgender men and thirty-one per cent of lesbian, bisexual and transgender women (Morgan & Bell, 2003).
3 Over 50,000.
4 1967 in England and Wales, 1980 in Scotland.
5 1973 in the *Diagnostic and Statistical Manual of Mental Disorders (DSM)* and 1992 in the *International Classification of Mental and Behavioural Disorders (ICD)* used by the World Health Organization.
6 A law that made it illegal to 'promote' homosexuality, this was relevant for sex education in schools. It became law in 1988 until 2003.
7 Transgender people must live in their acquired gender for at least two years and this be approved by a psychologist or psychiatrist.

Lesbian and gay timeline

Stonewall (http://www.stonewall.org.uk) provide a detailed and regularly updated timeline of events that have an impact on LGB people; an adapted

version is provided in Appendix 3 but this will need updating. The information contained in the timeline gives a good overview of the changes in the law and key events that have shaped the socio-cultural context of LGB people. Older clients will have been directly affected by some of these events, which might impact upon their openness in discussing their sexuality with therapists. This timeline does not provide any information on trans issues, but these could be added with information found on trans sites listed in the resources section.

If you use this timeline in training it can be given out to participants, asking them to skim through it for five minutes and then report back on what struck them. Alternatively, some of the significant events can be pointed out, e.g. the Wolfenden Report (Committee on Homosexual Offences and Prostitution, 1957) stated that 'private morality is not the law's business,' which began the process of decriminalising homosexuality.

Naming stereotypes

Stereotypes might be the first ideas somebody has about the sexuality and gender they think they might be: this could delay or make it confusing to come out as LGBT or seek out others if they feel they do not fit the stereotype. Stereotypes are culturally and historically dependent and so will shift over time and place. Asking participants to generate stereotypes highlights current cultural ideas and provides an opportunity to voice some of the less 'politically correct' ideas or beliefs they may have come across, hold, or wish to check out. It is better that these ideas are voiced so they can be discussed, and challenged, openly.

Participants are asked to generate stereotypes of the labels listed in Table 4.1, which can be drawn up on flip chart paper. Participants can work either as a large group or in small groups with each group taking a different label. It is important to note that transgender labels used by the medical profession include FTM – female to male, and MTF – male to female. However, these assume binary gender categories and so it is more correct to use the terms 'trans man' and 'trans woman' respectively (there are more on these definitions in Chapter 1).

Write participants' answers on a flip chart and once completed invite comments. For example, lesbians often have very few positive stereotypes whereas gay men sometimes attract some superficially positive ones. Stereotypes are often based on aspects of traditional heterosexual gender roles and so deviations from this are named (e.g. lesbians wearing 'comfortable shoes' or gay men being 'camp'). Damaging stereotypes, sometimes displayed in films such as Sharon Stone's murderous lesbian girlfriend in *Basic Instinct*, include that sexual minorities are perverted, sexually deviant, mentally ill or spreaders of sexually transmitted diseases. Again, the exercise provides an opportunity to challenge some of these; for example, although there are high

Table 4.1 Generating stereotypes

Gay men	*Lesbians*	*Bisexual men*	*Bisexual women*
e.g. dress well	e.g. man-haters	e.g. promiscuous	e.g. highly sexual

Heterosexual men	*Heterosexual women*	*Transgendered men*	*Transgendered women*
e.g. like sport	e.g. emotional	e.g. butch	e.g. glamorous

rates of HIV in gay male populations, there have been more heterosexuals living with HIV in the UK since 1999 (http://www.hpa.org.uk). It is also interesting to ask participants which aspects of the stereotypes they agree or disagree with in regard to those that were generated to fit themselves, and how do they feel about these.

Providing statistics

Although it is more than ten years old, Long's 1996 paper provided a challenge to many stereotypes that pervade society, examples of which are given below. The range of figures is broad enough that they probably still apply today.

- Gay men and lesbians do not desire and are not capable of permanent relationships. Forty-five to eighty per cent of lesbians, forty to sixty per cent of gay men are in steady relationship at any given time.
- Gay and lesbian relationships are less satisfactory than heterosexual relationships. No difference has been found and there is some evidence for greater sexual satisfaction.
- Lesbians and gays are not effective parents. No differences have been found between lesbian and heterosexual mothers in terms of maternal interests or child-rearing practices (limited research into gay fathers).

- Children raised by gay or lesbian parents will be psychologically damaged in some way (poor social adjustment, sexual identity confusion). No difference has been found in peer group popularity, social adjustment/competence, behavioural problems.
- In lesbian and gay couples, one partner usually plays the traditional feminine role and the other usually plays the traditional masculine role (butch/femme role division). Most lesbians and gays reject traditional masculine–feminine roles as a model for relationships. Most couples are in 'dual-worker' relationships and in relation to household tasks, decision-making processes and sexual behaviour roles seem to be based on skills or interest.

Diversity and sexual identity

There is no one way to be gay, lesbian, bisexual or transgender, just as there is no one way to be heterosexual, a man or a woman. Diversity within sexuality labels can be in some of the following areas and a useful exercise can be to ask participants to generate what the issues might be under each of the following headings.

Gender

The lives of lesbians and gay men are very different; there are different meeting places, socio-cultural norms and sexual practices. Same-sex venues are important for socialising, networking and meeting partners. Lesbians are less visible in the public eye than gay men, and perhaps because of this 'lesbian visibility' has been important, for example lesbians cutting their hair short to be recognisable to each other and perhaps as a political statement to wider society (Clark & Turner, 2007). However, the 1990s saw increased visibility of lesbians fitting more mainstream feminine presentations, with 'lipstick lesbians' or 'lesbian chic'. Today lesbians present in a wide variety of ways compared with the butch/femme dichotomies of the 1950s.

Race/ethnicity

People are likely to notice variation in race before they notice variation in sexuality. In a racist world, protection from this racism is essential from one's own community. To declare oneself as from a sexual minority within that community could potentially limit the support available to handle racism. For this reason, 'coming out' has been considered a White privilege. However, not being out can be associated in the LGBT community with shame, and racism within this community can limit support against homophobia. People from sexual and ethnic minorities therefore can face the

potential for double discrimination on the basis of racism and homophobia from mainstream society (this is further discussed in Chapter 6). There are different ethnic and cultural traditions around gender and sexuality roles and expectations. So for example, in Asian communities where arranged marriages are practised it can be extremely difficult to live and be accepted as LGBT. In Iran it is illegal to be lesbian or gay because it is no longer a mental illness, but because transsexuals are categorised under 'Gender Identity Disorder' (a psychiatric condition), trans people can receive medical assistance and care by the state.

Chapter 6 explores culture and sexuality in detail, but specific to LGB communities, same-sex sexual behaviour is found in many cultures although it might not be labelled 'homosexuality'

- Latin/Arab – the 'active' insertive sexual partner is viewed as heterosexual;
- Melanesian – the manhood ceremony involves young adolescents ingesting the semen of older men through fellatio to ingest 'manhood' and come of age;
- USA – A 'Boston marriage' in the nineteenth century involved two women who lived together like husband and wife to financially support each other, although this relationship was not necessarily sexual;
- over 30 African populations (including Nigeria, South Africa, The Sudan) have the concept of a female husband, similar to the Boston marriage above.

Similarly, trans people are accepted and have an honoured place in some societies (Denman, 2004):

- male Krishna devotees may imagine themselves to be female and sometimes dress in female clothing;
- hijra in India are considered a third-gender role that is neither male or female, so they may wear female clothing but have a beard. They often have sexual relationships with men but distinguish themselves from homosexuals;
- two-spirit people in Native American Indian societies are men or people with a Disorder of Sex Development (more on this in Chapter 1), living as women and honoured as shamans;
- Xanith in Oman occupy a position between men and women, wearing indeterminate clothing and so being able to be among women in purdah but go unaccompanied as men do.

In the West, such gender fluidity is viewed as a problem and constructed as a medical (e.g. Disorder of Sex Development) or mental (e.g. Gender Identity

Disorder) disorder that requires medical and/or psychiatric treatment, including surgery and hormone therapy.

Religion

Most of the world religions have been interpreted to prohibit same-sex sexual practices, or practices such as anal sex, and see them as sinful. For a religious client, their faith and sexuality may be in conflict. Fortunately, many LGB faith groups exist as a resource (see the resources section at the end of this chapter). In more rural communities alternative venues to bars clubs, which may conflict with religious practices such as not drinking alcohol, may not be available.

Age

Across the lifespan there are specific issues for LGBT people (D'Augelli & Patterson (1994) go into these issues in depth). These range from 'coming out' (described in more detail later in this chapter); parenting issues in mid-life; or being an older adult who lived in a time when their sexuality was considered criminal and a mental illness. In addition, LGB social spaces tend to be geared towards those under 50 years old. This makes it more difficult for older LGBT people to meet friends or partners, particularly if they came out or transitioned later in life (perhaps after children and marriage) and so might not have a social network. (Sex and sexuality across the lifespan in general is discussed further in Chapter 5).

Class

Class may influence having the funds to access resources such as Pride events, the confidence and verbosity to speak about one's sexuality and expecting to be accepted, and seeing oneself represented in LGB media will all be influenced by class. However, in other ways visiting the only gay bar in the town cuts across class barriers as having sexuality in common brings people together. Keogh *et al.* (2004) describe how working class men are more likely to face discrimination because of their sexuality at work, but are less likely to attend LGB community events – where they might gain a sense of belonging and support. For trans people, being in a low socio-economic group may also affect access to funds to pay for procedures not covered by the NHS (e.g. electrolysis), the option to be seen in a private clinic (which may not insist on an all or nothing transition which the NHS might), or the risk of unemployment (e.g. due to prejudice while living as the preferred gender prior to any medical interventions to assist this transition such as hormone treatment).

Sexuality

There are further minority sexualities and sub-cultures within LGBT communities, such as the sadomasochism community (Langdridge & Barker, 2007). These individuals can face prejudice and rejection from the wider LGBT community. There is also a debate about whether trans issues should be grouped together with LGB issues, as although a transsexual person's sexuality label might change if they change gender, as might their partner's, this change might have no meaning or be rejected by those involved (so a heterosexual partner of a trans woman may not consider herself to now be in a lesbian relationship). The connection between sexuality and transsexuality is a complex consideration of development, definition, association, perspective etc. Whereas sexuality is increasingly been seen as fluid (especially with identities such as 'queer' being available), this is less the case when it comes to gender. And yet there is a huge range of both behavioural gendered characteristics, as well as biological variation (e.g. women who have facial hair, men who develop some breast tissue etc.).

Rural/urban

The environmental contexts of rural and urban settings will impact upon other people's exposure to LGBT lives and so their reaction to such things as someone in the community 'coming out', same-sex partners living together or moving into the area, or someone transitioning gender. For LGBT people, access to supportive communities or places to socialise and meet friends and partners might be limited in rural settings.

Ability

Meeting friends and partners if an LGBT person has a physical or learning disability can be a challenge. There are some LGB disability specialist groups, such as for people who are deaf, but by and large the social network is geared to able-bodied people, which in extreme can be body fascistic (for examples pick up a copy of the gay male press to be met by bulging muscles and six packs on nearly every page). Cambridge (1997) reports that LGB people with learning disabilities are less likely to have their support needs met and men are at a higher than average risk of contracting HIV. Trans people might have difficulty being heard and responded to if they have a learning disability, particularly when their expressions of gender and sexuality have been controlled and policed by carers or residential staff.

HETEROSEXISM AND HOMOPHOBIA/BIPHOBIA/TRANSPHOBIA

This section starts with some important terminology; in training sessions participants can be asked to give examples to ensure understanding:

- homophobia: an irrational fear of homosexuality;
- biphobia: an irrational fear of bisexuality (by heterosexuals or homosexuals);
- heterosexism: a world view, a value-system that prizes heterosexuality, assumes it is the only manifestation of love and sexuality and devalues all that is not heterosexual (Herek, 1986).

The term 'homophobia' was first used in 1869 by Dr Benkert in Hungary and introduced to the English language in the 1890s by the sexologist Havelock Ellis. It has since been criticised (e.g. Kitzinger & Perkins, 1993) because it individualises and depoliticises the oppression of LGB people. Alternatively, 'heterosexism' places such oppression within a socio-cultural context that is learnt and sanctioned by the dominant culture. As yet, there is not an equivalent term in use with regards to trans people, but the term 'transphobia' is used (Whittle, 2006). Examples of heterosexism and transphobia in psychology include normative theories of development (which exclude or pathologise LGBT experiences) or the invisibility of LGBT issues and lives in teaching and writing.

- Sexual prejudice: all negative attitudes based on sexual orientation, whether the target is homosexual, bisexual, or heterosexual (Herek, 1999).

This term is used increasingly in psychological literature (Hegarty, 2006) and widens the lens of oppression again to include all those engaging in non-mainstream sexual practices (and so would include heterosexuals who have non-monogamous relationship or practice sadomasochism).

THERAPIES AIMED AT CHANGING SEXUAL ORIENTATION/CONVERSION THERAPIES

An issue to discuss during training is how would you respond if a client asks for help to change their sexual behaviour? There might be various reasons why someone might ask this: it could be because they are not happy with the kinds of sex they are having, the type of partner they are having it with or the context in which it occurs. It is worth exploring with the client why they consider their sexual behaviour to be a problem, when it first

started to be constructed as problematic, and who else might agree or disagree with this view? It is important that the therapist's ideas of what is 'appropriate' sexual behaviour do not guide the therapy, and supervision can be helpful for expressing beliefs about sex and sexuality held by the therapist. There may be some circumstances where helping the client address an aspect of their sexual behaviour is entirely appropriate; for example a client may struggle to use condoms when taking recreational drugs and want to find strategies to prompt him to do so. However, any therapy that is based on heterosexist prejudices, internalised by the client or therapist, should never be conducted.

Therapy aimed at changing sexual orientation was routinely offered when homosexuality was viewed as a mental illness before *DSM-III* in 1973 (American Psychiatric Association). 'Cures' for homosexuality included medical 'treatments' such as surgical interventions (including sterilisation, lobotomy, clitoridectomy), chemical interventions (including hormone injections, sexual depressants), psychological interventions (including hypnosis, aversion therapy using emetics and shock) and other procedures (such as cold sitz baths and 'homo-anonymous' which was similar to Alcoholics Anonymous) (Kutchins & Kirk, 1999). Criticism of these approaches came from the Gay Liberation Movement and from within the profession, with the likes of Kinsey *et al.* reporting the frequency and hence 'normality' of same-sex sexual practices for men (1948) and women (1953). In 1979, Masters and Johnson's book *Homosexuality in Perspective*, also refuted homosexuality as a mental illness, however, unfortunately they claimed to be able to change the sexual preferences of homosexuals to a 'normal' heterosexual pattern. In general, criticisms have centred on how these approaches harm clients, the prejudice inherent in their theoretical basis, their violation of human rights and evidence that they have minimal effectiveness in helping to change sexual orientation. A comprehensive description of the issues around conversion therapy is provided by Shidlo *et al.* (2002).

Since 1973, conversion therapy is not available on the NHS, however it is still researched, taught and offered, particularly in the USA. The main proponent of this approach is Nicolosi (1991) who offers 'reparative therapy' that is based on psychodynamic theory and the premise that non-heterosexual adjustment is never a satisfactory resolution of sexual identity development. The National Association for Research and Therapy of Homosexuality offers 'evidence' and 'treatment' to support this approach. The film *But I'm a Cheerleader* offers a comical insight into what happens in conversion 'camps', and examples of the rules for such places are on the Love In Action website (http://www.loveinaction.org), which opposes reparative therapy.

The American Psychiatric Association (1998) has issued a position statement on conversion therapies:

1 Homosexuality is not a diagnosable disorder and any therapy based on this premise is unethical.
2 As a general principle a therapist should not determine the goal of treatment to changing sexuality coercively or through subtle influence.
3 Reparative therapy uses theories and methods that make it difficult to find scientific evidence for its effectiveness.

The Australian Psychological Society (2000a) has produced a similar statement.

Exercise 4.1 Case study

Mahmod is a 30-year-old Kurdish man who presents asking to change his sexual behaviour from having casual sex with men to dating women. He has been in the UK for three years and has no friends or family in this country and is unemployed. He comes from a large family where he did not feel emotionally supported, was criticised by his father and found relationships and intimacy with women difficult. Since he came to the UK he found that he could find casual sex with men easily but felt shame and guilt at this as he wanted to have a family and succeed as he believed it would gain his father's and family's approval.

How would you work with this client? On the one hand, there might be the argument that for religious, personal or family reasons a therapist should assist him to change his sexual behaviour as it causes him distress; on the other, there is the argument that such assistance to change his sexual behaviour should never be encouraged as a therapeutic goal and encouraging self-acceptance may be more helpful. How might you negotiate reformulation if you held a different view to him on the goal of changing his sexual behaviour?

THEORIES OF SEXUALITY AND TRANSGENDER

When teaching theories of sexuality or gender, it first needs to be asked why are we curious about this? People do not ask why are people heterosexual or the gender they are, so putting LGBT people under the microscope hints at an unspoken assumption that it is questionable or dubious to identify this way. There is also a moral agenda that such theories would indicate either that people do not choose their sexuality or degrees of gender, or else that they do, and could be 'treated' or reformed. However, clients may be

Table 4.2 Poles of the theories of sexuality and gender

Essentialist	*Social Constructionist*
• Nature: innate	• Nurture: choice
• Fixed and immutable	• Fluid and changeable
• Occurs across cultures, species and throughout history	• Shaped by cultural and temporal norms
• Provides a 'cause'/linear explanation	• Complex, multifaceted explanation

genuinely curious about why they are LGBT, and to explore this with them it is useful to know some of the theories of sexuality and transgender to validate or challenge their views, depending on what would be more helpful. Theories of sexuality and gender tend to fall into two camps, set out in Table 4.2.

With regards to sexuality, essentialist views could be used to pathologise homosexuality as a 'mutation' or non-adaptive. Alternatively, social constructionist views could be used to pathologise and offer conversion therapy. Gender tends to be constructed as fixed, based on essentialist unquestioned assumptions and so social constructionist ideas of gender are more hidden.

Biological explanations

Biological explanations suggest there are genetic or anatomical differences between heterosexual people and gay men or lesbians. For example, research has found differences in brain structure, prenatal exposure to androgens, fraternal birth order, differences in finger length and linked homosexuality to left-handedness. A comprehensive review of these theories is provided by Wilson and Rahman (2005). Socio-biological theories also exist to explain the social advantages of a biological predisposition to homosexuality for the group. These are based on the assumption that LG people do not have children, for example, LG people provide an extra pair of hands to help or there is a reduction in competition for mates. Denman (2004) describes these theories in more detail. For trans people, biological explanations are politically important, as trans people must convince psychiatrists that they have always felt in the wrong gender, that it is innate and not a conscious choice, and so be allowed access to gender reassignment surgery and procedures.

Psychiatric explanations

Psychiatry historically pathologised homosexuality as a mental disorder under various different titles:

- *DSM-I* (APA, 1952) 'sociopathic personality disorder'.
- *DSM-II* (APA, 1968) 'sexual orientation disorder'.
- *DSM-III* (APA, 1973) 'egodystonic homosexuality'. The criteria for this classification were:

> 1. The individual complains that heterosexual arousal is persistently absent or weak and significantly interferes with initiating or maintaining wanted heterosexual relationships
> 2. There is a sustained pattern of homosexual arousal that the individual explicitly states has been unwanted and a persistent source of distress.
>
> (APA, 1973)

There is no question raised about why an individual might be distressed at being homosexual on a socio-political level, instead, understandable distress generated by prejudice and oppression was pathologised.

- *DSM-III-R* (APA, 1987) 'egodystonic homosexuality' was removed and this is the only version of DSM where homosexuality is not pathologised;
- *DSM-IV* (APA, 1994) 'sexual disorder not otherwise specified'. The criteria for this being similar to that of egodystonic homosexuality: 'sexual disturbances including persistent and marked distress about sexual orientation'.

Detailed information about the changing fate of homosexuality in the *DSM* is provided by Kutchins and Kirk (1999). It is worth noting that the World Health Organization did not declassify homosexuality as a mental disorder until 1992 with *ICD-10*, which retains the classification of egodystonic sexual orientation.

Trans people are viewed as having the mental disorder 'Gender Dysphoria' in *ICD* and 'Gender Identity Disorder' in *DSM*. In Britain, to obtain gender reassignment surgery on the NHS individuals must live as their acquired gender for two years and be assessed by a psychiatrist. This medicalised approach is in contrast to how other cultures may view transgender mentioned earlier.

Psychological explanations

It would be a book in itself (and it has been, e.g. Davies & Neal, 2000) to try to list every psychological theory's consideration of homosexuality. However, the main theories relating to the psychology are detailed below.

Learning theory

Classical learning theory suggests that a resulting homosexual orientation will arise from exposure to adverse heterosexual experiences and positive homosexual ones. This theory has been use to justify 'treatments' such as the use of emetics to make a patient feel nauseous and vomit when viewing homosexual images (often porn). However, there is no substantive evidence to support this theory. Learning theory in relation to trans involves parental encouragement of 'other' gender behaviour and discouragement of matching gendered play, or the individual's wish to avoid homosexuality (e.g. Bancroft, 1989). There is no evidence to support these views.

Psychoanalytic theory

Psychoanalytic theories have had the most to say about sexuality; some useful examples include Drescher (1999) and Drescher *et al.* (2003). Freud did not label homosexuality as mental illness but considered that we are all born bisexual. However, he proposed that this would change to heterosexuality with normal development, and so in his Oedipus Complex theory homosexuality was viewed as a perverse orientation, or a developmental disorder or arrest. Later theories have viewed homosexuality as pathological (e.g. Socarides, 1963), justifying exclusion of openly homosexual people to train as analysts (which has only changed in the last 25 years). This meant all psychoanalytic writing was about clients and not personal experience, a situation that has changed in latter years (e.g. O'Connor & Ryan, 1993). This has caused many splits in recent psychoanalytic theories, e.g. between those who still view homosexuality as pathological and those who do not. Psychoanalytic theorists also have developed theory about transsexuals. However, sadly this theory has also been used to pathologise, e.g. involving unresolved separation anxiety from the mother (e.g. Person & Ovesey, 1978), which again has no evidence. However, recent developments (e.g. Di Ceglie, 2000) have taken a less pathologising, although still psychiatric, view.

Systemic theory

Systemic theories have ignored sexuality, however early models (e.g. structural therapy or *The Family Life Cycle* by Carter & McGoldrick, 1980) assume that heterosexuality is the norm. The definition of 'family' is often taken as blood relatives in a nuclear family structure. Historically the marriage bond was privileged in the use of genograms. Such a view can create one way of seeing relationships and families, a 'universe', as opposed to the 'multiverse' that Maturana and Varela (1986) place at the centre of

systemic theory, particularly with the strong influence that social constructionism has played in later developments. However, there is a small amount of literature about lesbian and gay lives applying this theory (e.g. Malley & Tasker, 1999). In general, this approach does not work with the notion of pathology in the individual but explores how problems arise in socio-cultural contexts. It can therefore help to challenge oppressive social discourses and address issues of power, as well as explore alternate perspectives on gender and sexuality.

Cognitive Behavioural theory

Beckian cognitive behavioural therapy also ignores sexuality in its theorising, but it does take account of environmental influences and so could be used to address experiences of heterosexism and transphobia, and case studies have been published doing this (e.g. Padesky, 1989). Used inappropriately, clients' experiences of heterosexism or transphobia could be viewed as 'negative automatic thoughts' to be corrected or newer methods, such as Acceptance and Commitment Therapy, could also depoliticise heterosexist and prejudicial experiences. Ellis, the main proponent of Rational Emotive Therapy, labelled people who were exclusively homosexual as abnormal (1965), even psychotic, which he later retracted (1976, 2001). Behavioural therapy has also been used to desensitise clients of their same-sex sexual responses on the premise that these responses were due to faulty learning (Barlow, 1973). Martell *et al.* (2004) write about how to use this approach ethically with LGB clients.

Contemporary theory

Psychology overall has recently shifted away from researching and explaining the cause of homosexuality, to examining the assumptions that underlie the construct of heterosexuality, e.g. patriarchy and enforcing gender roles. There has also been a move to examine the origin of LGBT hostility, e.g. that it violates established gender codes. Along with this have come the critiques of the construct of homophobia, in favour of heterosexism, heterosexual privilege and sexual prejudice. This shift has been heavily influenced by post-modernism and feminism. Two other influential theories, queer theory and continuum theories, are detailed below.

Queer theory

Queer theory considers identities such as gender and sexuality as not being fixed. In addition, there are no fixed groups with common characteristics or interests e.g. 'women' or 'lesbians'. Instead, identities are *performed* (Butler, 1990) based on prevailing socio-cultural norms. Those with power

categorise and regulate the lived experiences of minority peoples, positioning them as 'the other', deviating from the dominant, and thus 'desirable', norm (Foucault, 1972). Queer theory tends to reside in academia and has not been taught or adopted by many practising psychologists. However, social constructionism, as a close cousin not specifically about sexuality, is widely taught and so there is a space for queer theory to move into. Butler and Byrne (2007) give examples of the usefulness of this theory in their work.

Continuum theories

These started with Kinsey who said:

> Not all things are black nor all things white. It is a fundamental of taxonomy that nature rarely deals with discrete categories. Only the human mind invents categories and tries to force facts into separated pigeon-holes. The living world is a continuum in each and every one of its aspects. The sooner we learn this concerning human sexual behaviour the sooner we shall reach a sound understanding of the realities of sex.
>
> (Kinsey *et al.*, 1948: 639)

Kinsey *et al.* (1953) created a seven-point continuum of sexual behaviour ranging from exclusively homosexual to exclusively heterosexual (for more information visit www.kinseyinstitute.org). Klein (1983) and Klein *et al.* (1985) developed the construct of sexuality beyond just sexual behaviour and proposed it was made up of seven components: sexual behaviour; emotional preference; sexual fantasies; sexual attraction; social preference; life style; social world and community; self-identification. Klein suggested a continuum existed for each of these components that will change if considered in the past, present or image of the ideal.

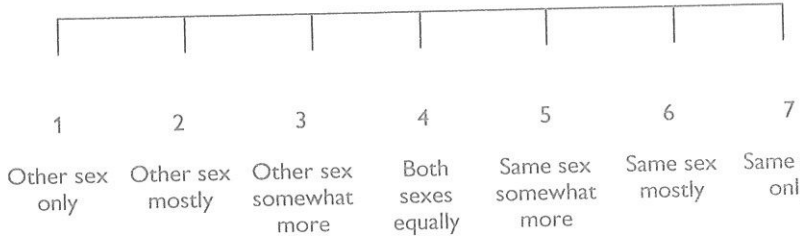

Figure 4.1 Klein Sexual Orientation Scale. Produced with data from Klein, F. (1993). *The bisexual option* (2nd edn). New York: Haworth Press.

Exercise 4.2 The Klein Scale

Print numbers 1–7 and the scale descriptors on pieces of A4 paper and put them together on the floor in a line from one side of the room to the other. Ask participants to line up behind the number that best represents them in response to the following questions.

- Social preference: with members of which sex do you socialise?
- Lifestyle preference: what is the gender ratio of the places where you choose to socialise?
- Emotional preference: members of which sex do you love and like mostly?
- Sexual identity: with which group do you identify your sexual identity?
- Sexual fantasies: who are your sexual fantasies about?
- Sexual attraction: to whom are you sexually attracted?
- Sexual behaviour: with whom have you actually had sex?

Note: these questions are ordered loosely in descending order of privacy. The trainer needs to judge whether asking the latter questions will be appropriate for participants, for example, on an ongoing course participants may not want to reveal their sexual fantasies to each other. However, you can still ask the question and ask participants to sit down when they wish, then ask them why it was they might have felt uncomfortable revealing this. Also, ask participants if they would have stood somewhere different if the exercises had been done five years ago or if they could imagine standing somewhere different in future. What do they learn from this?

These scales are in relation to sexuality but scales can also be developed in relation to gender to emphasise the fluidity of gender as well. This is an interesting way to draw out gender role stereotypes and how people position themselves in relation to these. To do this as a lineal scale (as with sexuality) from male to female would mean that as one moved towards the female pole, aspects of a masculine identity would have to be given up, when in fact these two aspects of identity might exist simultaneously (for example, a woman who likes servicing her motorbike and wearing heels when she goes out for a night). A better model would be to represent masculinity and femininity on a graph (Figure 4.2).

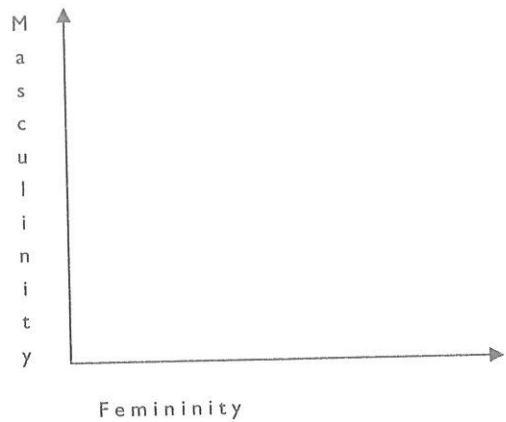

Figure 4.2 Gender identity graph.

Exercise 4.3 A scale of gender

Place yourself, or ask participants to place themselves on the above graph to represent how masculine and feminine they feel. Consider how this might change in different contexts: e.g. at work, on a night out, in bed, on a dance floor, driving?

To conclude about theories of sexuality – our understanding of the nature and origins of sexuality develops as a function of:

- the questions we ask;
- the methods by which we seek the answers;
- how we interpret the data;
- all further limited by the cultural context in which we work and the lens through which we see the world.

Exercise 4.4 Reflection on theories of sexuality

Having considered the theories, where would you position your work? Which of the theories do you think are essentialist or social constructionist? Which theories might be helpful to your clients? Which do you feel more comfortable with?

WORKING WITH LGBT CLIENTS

This section is often the 'point' of doing teaching in this area. Both LGBT and heterosexual therapists can develop skills in working with clients who are different from themselves in terms of sexuality or gender. However, there are issues specific to heterosexual therapists and LGBT therapists; issues pertaining to the former are now considered, issues pertaining to the latter are discussed at the end of this chapter.

Heterosexual therapists may have a number of concerns in working with LGBT clients, some of which are discussed by Spellman (1999) and Accoroni (2006). Such issues might include not knowing how to raise the issues of sexuality or gender variance, who has responsibility to raise it (the therapist or the client) and not feeling knowledgeable about relevant LGBT issues. Feeling a lack of knowledge, inexperience, and hence feeling deskilled, can be compounded by the lack of teaching on LGBT issues and integration into training curricula. It is important to position LGBT training as part of an ongoing process that requires revision, expansion and updating. In his sexuality training, Dominic Davies (personal communication) has adapted suggestions from Blumenfeld (1992) to suggest heterosexual therapists conduct 'homowork' to understand how it might feel to be lesbian or gay in today's society, including:

- buying a gay or lesbian magazine and reading it in public;
- wearing a pro-LGBT T-shirt or badge;
- holding hands with someone of the same sex in public;
- keeping your heterosexuality in 'the closet' for a week by not discussing it with anyone, e.g. if talking about what you did at the weekend do not mention your partner's name or gender.

You might also like to try out the following in relation to gender:

- go shopping in your local supermarket while cross-dressed;
- try something on the other end of the stereotypical gender spectrum you have never done before, e.g. if you are very feminine go paintballing, if very masculine get your nails manicured.

What do LGBT clients want their therapist to know? Long *et al.* (1993) (cited in Long, 1996) interviewed LGB clients and identified the following areas, which can also apply to transgender:

- awareness of 'invisibility' in society;
- 'coming out' as a continual process;
- social and political history of LGBT;

- awareness of effects of homo/transphobia, including the impact of violence.

What is important to emphasise is that when working with LGBT clients, the therapist should be alert to whether their sexuality/transgender *per se* is the problem and if so *who* is it a problem for?

If sexuality is problematic for LGB clients, some of the psychological pressures they may present with include the following:

- Dealing with heterosexism:
  - internal: heterosexism/homophobia might have been internalised to cause low self-esteem, self-harm or thoughts of suicide (this is sometimes referred to as 'internalised homophobia', e.g. Wagner *et al.*, 1996);
  - external: having to cope with bullying, verbal or physical abuse, heterosexual privilege etc.;
  - institutional: having to cope with prejudice and discrimination, in health, education, mental health systems etc. (e.g. McFarlane, 1998);
  - difficulty accessing services (e.g. McFarlane, 1998; King *et al.*, 2003).
- The influence of LGB culture and sub-cultures: alcohol and drugs (there are higher rates of drug and alcohol use than in the general population, Hughes & Eliason, 2002), the prevalence of HIV in gay male communities, the pressures of body image.
- Increased suicide and self-harm in youth (Rivers, 1997).
- Negotiating sexual relationships within relationships.
- Considering issues related to wanting children and parenting.
- Support in illness and old age.
- Employment issues such as discrimination at work.
- 'Coming out.'

Issues to do with coming out deserve a particular mention; they connect to other areas in this chapter and are also discussed in Chapter 5 and in Chapter 6 in relation to Black and ethnic minority LGB people. Coming out, disclosing one's sexual identity to others, can happen for the first time at any point in a person's life and from then on it is a repeatable process as new environments and people are encountered (Cowie & Rivers, 2000). Some research suggests that gay men come out on average at a younger age than lesbians (Savin-Williams, 1990). Numerous models of the process of coming out have been developed, e.g. Cass (1979), Woodman and Lenna (1980), Coleman (1982), D'Augelli (1994) and Rivers (1997) to name a few. Cass's six-stage model is one of the most widely known (Ritter & Terndrup, 2002) and so is described below as an example.

- Identity confusion: the individual begins to question whether they are heterosexual as they realise they have thoughts, feelings or behaviours that might be classified as homosexual.
- Identity comparison: the individual considers the consequences of what it might mean to be homosexual in relation to their former sense of self and begins to develop a new meaning system.
- Identity tolerance: the individual begins to recognise that they might be homosexual and seeks out contact with other homosexual people to compensate for feelings of alienation in heterosexual society.
- Identity acceptance: the individual will prefer homosexual social contact to heterosexual as they feel supported and a sense of belonging and start to selectively disclose their identity.
- Identity pride: the individual may experience anger with wider society because of heterosexism and homophobia and so split the world into supportive homosexuals and oppressive heterosexuals, contact with other homosexuals is maximised.
- Identity synthesis: the individual no longer draws a clear line between homosexuals and heterosexuals, can recognise similarities between the two and their sexuality is reduced to just one part of their identity among others.

However, these models have been criticised because they assume a one-off lineal progression through stages and that someone is either heterosexual or gay (therefore not accounting for if someone is bisexual or their sexuality or gender changes over time – Davies, 1996). In addition, they do not differentiate male and female experiences, consider the influences of a person's social environment or recognise that all the stages do not fit with the experience of large numbers of LG people (Langdridge, 2007).

Transgender clients might present in therapy with the following specific psychological issues:

- dealing with stigma, discrimination and prejudice;
- rejection from the gendered group that has been reassigned;
- experiencing verbal and physical aggression;
- lack of funds due to the expense of treatments and difficulty working because of discrimination;
- not wanting surgery, only some kinds of medical intervention, but only being offered all or nothing;
- post-operative regret tends to be caused by poor surgical outcome or unrealistic expectations of the surgery (Denman, 2004);
- adjusting to changes in relationships with partners and friends.

Giving participants case examples to work on in small groups is a good way to consider how they would feel, think and what they would do if working

with LGBT clients. It is good to include scenarios that reflect the clients that participants will be working with, so for example, with clinical psychology trainees include scenarios that cover older adults, learning disabilities, adolescence (including issues of coming out) and someone from an ethnic minority. It is also useful to include trans clients so that participants can consider the medical and societal oppression and prejudice that these clients face day-to-day. After working on the role plays for 20–30 minutes, have participants feed back from each different scenario and invite the rest of the class to comment or add to points raised. This is another opportunity to provide resources, information and do some myth busting.

SEXUAL AND GENDER MINORITY THERAPY

Gay Affirmative Therapy (GAT) was a term that grew during the 1980s and 1990s indicating that the therapist affirms an LGB identity as equally positive in experience and expression as a heterosexual identity. It is not a new form of therapy but an adjunct to existing therapy models that takes the above stance. Whole books have been written on the subject, e.g. Ritter and Terndrup (2002) and Kort (2007). GAT developed because of evidence of harmful therapeutic practice (Milton, 1998), including a lack of knowledge of LGB concerns and consequential reliance on stereotypical assumptions about LGB people, viewing them as 'pathological', overemphasising the relevance of their sexuality in assessing their presenting problems and underestimating the effects of prejudice and discrimination on clients' lives.

Gabriel and Davies (2000) extended the term to 'sexuality affirmative therapy' to include lesbian, bisexual and queer identities. There have been critics of both these terms (e.g. Simon & Whitfield, 1995) questioning what is being affirmed, and whether the therapist has the authority to decide this and they ask instead what meaning the client might make of their sexuality? Davies (personal communication) has since further extended the term to 'sexual and gender minority therapy' to also include transsexuals and remove the concept of 'affirming'.

The basic principles of this approach, drawn from commonalities across the literature and which fit in any therapeutic model, are:

- the therapist should to be aware and comfortable with their own sexuality;
- the therapist should respect the client's sexuality, lifestyle and culture, attitudes and beliefs;
- the therapist should be aware of the pervasiveness of heterosexism/homophobia and the effects of this on clients' lives;
- the therapist should be aware of the socio-political history of LGBT people and the diversity within LGBT communities.

There are other principles that are recommended by different authors, which might not fit with every therapeutic approach, e.g. 'the therapist should support the development of a positive self-identity and LGBT network' (Davies, 1996) which might not fit with less directive therapeutic modalities.

Perhaps one of the most definitive guidelines for working with LGB clients is from the American Psychological Association's Division 44 (the lesbian and gay section) (http://www.apa.org/pi/lgbc/publications/guidelines.html) and for trans clients the World Professional Association for Transgender Health's *Standards of Care for Gender Identity Disorders* (http://www.wpath.org/Documents2/socu6.pdf). In addition, the Australian Psychological Society (2000b) has produced *Ethical guidelines for psychological practice with lesbian, gay and bisexual clients* and the British Association for Counselling and Psychotherapy (BACP) has produced a review of research on counselling and psychotherapy with LGBT clients (King *et al.*, 2007). At the time of writing, the British Psychological Society was in the process of developing a similar guide for LGBT clients in a British context. A measure of how 'gay affirmative' a therapist's practice is has been developed by Crisp (2006) and Dillon and Worthington (2003).

When including these principles in training, you can ask participants to come up with how they will show respect and awareness with clients. This sometimes leads to discussions about disclosure of one's own sexuality if asked by a client, which is covered in the section for LGBT therapists later.

LEGISLATION

The importance of therapists being aware of the historic context and current legislation has been cited by LGBT clients, and is one way of demonstrating an interest and some knowledge of factors affecting LGBT lives. The lesbian and gay timeline produced by Stonewall (pp. 126–128 this chapter) is an easy way of accessing legislative history, but not for trans people. Recent legislative amendments in the UK that are important to mention include:

- 2001 age of consent for gay men lowered to 16 (17 in Northern Ireland) to be equal with heterosexuals;
- 2002 same sex couples allowed to apply for joint adoption (still banned in Scotland);
- 2003 Section 28 repealed (since 1988) which prohibited the 'promotion' of homosexuality;
- 2004 buggery and gross indecency was removed from the Sexual Offences Act.

There has also been new legislation that affects the lives of LGBT people.

- The Civil Partnership Act 2004 – This came into force on 5th December 2005. It allows a legal partnership between two people regardless of gender, having parity of treatment with spouses, including survivor pensions, immigration, equal tax treatment, protection against domestic violence and next of kin rights.
- The Gender Recognition Act 2004 – This allows transgender individuals recognition of their acquired gender and protection under discrimination through the Sex Discrimination Act (1975).
- Equality Act (Sexual Orientation) Regulations 2007 – This came into force on 30th April 2007, prohibiting sexual orientation discrimination in the provision of goods, facilities and services. A consequence of this is that sexuality should now be included in all diversity training provided by employers (the Department of Health (2006) has produced standards for this training for the NHS).

However, despite all these excellent recent changes, there are still ongoing problems for LGBT people living in a discriminatory society.

- Hate crimes against LGBT people remain a common occurrence, e.g. the 1999 Admiral Duncan pub bombing aimed at the gay community; in October 2005, Jody Dobrowski was murdered for being gay. A comprehensive consideration of the heterosexist culture that can support and generate these hate crimes is provided by Herek and Berrill (1992).
- For under 18-year-old LGBTs, Stonewall (Hunt & Jensen, 2006) report that 65 per cent have experienced homophobic bullying in schools (rising to 75 per cent in faith schools), yet only 23 per cent of pupils report that their school gives the clear message that homophobic bulling is wrong. Of those bullied, 92 per cent experienced verbal abuse, 41 per cent physical abuse, 17 per cent had received death threats, 13 per cent threatened with a weapon and 12 per cent sexually assaulted. However, only 58 per cent reported this bullying, and of these reported cases 62 per cent of the time nothing was done. Rivers (2000) writes about the long-term consequences of such bullying at this early, informative age. O'Loan *et al.* (2006) have produced a comprehensive report about homophobic bullying in Scotland and provide clear guidelines on dealing with this.
- Seventy countries still criminalise same-sex relations, punishment includes the death sentence. Amnesty International campaign against this and have produced various country reports documenting the ill-treatment of LGBT people around the world (http://www.amnesty.org.uk/content.asp?CategoryID=876).

ISSUES FOR LGBT THERAPISTS

LGBT therapists face unique issues when working with LGBT clients. These include clients holding high expectations that the therapist will understand them, as well as the possibility that the clients' fears, anxieties and concerns may be similar to those of the therapist. On a practical level, LGBT communities are small, particularly outside large cities, and so therapists may run into clients at community events (such as film festivals or Pride gatherings). This may lead therapists to feel like they are 'living in a fishbowl', where their best behaviour is expected at all times as their personal life and professional credibility may be linked. Therapists may feel they have to restrict their social life or behaviour at social events, which could lead to resentment and frustration. The importance of preparing for such eventualities is essential, openly discussing with clients the likelihood of running into each other socially and a plan for if this happens.

However, having a plan may require the therapist to disclose their sexuality. There are numerous views on whether this is advisable. One view is that therapists have an ethical responsibility to disclose if a client asks directly. Another view is to find out what difference it will make to the client if the answer is one thing or another, and then decide together if the therapist should disclose. Some therapists, particularly those who work psychoanalytically, suggest that one should never disclose, so that the client can project their own fantasies onto the therapist and these can be worked with. However, more recent psychoanalytic writers have rejected this view and encourage disclosure (e.g. Isay, 1989).

A related point is whether to disclose one's sexuality when doing training. If the trainer is LGBT, they risk feeling exposed or the participants feeling resistant in sharing or checking out ideas that they fear might be prejudiced or incorrect. However, research indicates that contact, or 'exposure', to LGBT individuals is an effective way of reducing prejudice and providing credible information (Peel, 2002). If the trainer is heterosexual, it gives the message that these issues are important for everyone to be aware of, and not just those with a 'vested interest'. Ultimately it is up to the comfort of the trainer to decide, but modelling 'coming out', and doing so at the start of the training, can create an atmosphere of trust and openness to sharing.

Given the smallness of LGBT communities, LGBT therapists may find themselves in dual relationships with clients, defined by the BACP as:

> Dual relationships arise when the practitioner has two or more kinds of relationship concurrently with a client, for example client and trainee, acquaintance and client, colleague and supervisee. The existence of a dual relationship with a client is seldom neutral and can have a powerful beneficial or detrimental impact that may not always be easily foreseeable. For these reasons practitioners are required to consider the

> implications of entering into dual relationships with clients, to avoid entering into relationships that are likely to be detrimental to clients, and to be readily accountable to clients and colleagues for any dual relationships that occur.
>
> (BACP, 2007: 5)

Despite these concerns, there might also be some advantages to holding dual relationships with clients. Laura Brown (1984: 15) suggests that this position allows for 'ethics that flow with our interdependencies rather than values that create false dichotomies'. We can therefore be human and real with our clients, although a clear sense of our own boundaries is necessary to remain our professional selves. If running a workshop with LGBT therapists, ask participants what might be some of the complications that dual relationships pose, as well as the advantages? Further exploration of the issue of dual relationships is provided by Gabriel (2005).

USEFUL RESOURCES

LGBT history month is in February each year and is supported by the Department of Health. It recognises and celebrates the contribution of LGBT people in history. (http://www.lgbthistorymonth.org.uk).

The Department of Health has set up a Sexual Orientation and Gender Identity Advisory Group that has commissioned and produced the following resources:

- *Real Stories, Real Lives: LGBT People and The NHS* – a DVD to be used as a practical tool in training staff and raising awareness;
- *An introduction to working with Lesbian, Gay and Bisexual people*;
- *Core Standards for training on Sexual Orientation*;
- *Monitoring of Sexual Orientation in the Health Sector*;
- *Harassment and Sexual Orientation in the Health Sector*;
- *A guide for young trans people in the UK.*

All of these and further resources are found on: http://www.dh.gov.uk/EqualityAndHumanRights.

Further reading

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Hutchins, L. & Kaahumanu, L. (eds) (1991). *Bi any other name*. Boston: Alyson.

Mole, S. (1995). *Colours of the rainbow: Exploring issues of sexuality and difference. A resource for teachers, governors, parents and carers*. London: Camden Health Promotion Service.

Pierce Buxton, A. (1994). *The other side of the closet: The coming-out crisis for straight spouses and families*. New York: John Wiley & Sons.
Smith, A. & Calvery, J. (2001). *Opening doors: Working with older lesbian and gay men*. London: Age Concern.

Useful websites

Lesbian and Gay

- LGBT Health website
  http://www.healthwithpride.nsh.uk
- PACE
  http://www.pacehealth.org.uk
- Stonewall
  http://www.stonewall.org.uk
- Regard. An organisation for disabled LGBT people.
  http://www.regard.org.uk
- Broken Rainbow. Domestic violence support.
  http://www.broken-rainbow.org.uk
- *LGBT Religious groups*
  Jewish: http://www.jglg.org.uk
  Muslim: http://www.imaan.org.uk/
  Christian: http://www.lgcm.org.uk
  Catholic: http://www.questgaycatholic.org.uk/home.asp
  Buddhist: www.sgi-uk.org/

Transgender

- Gender Trust
  http://www.gendertrust.org.uk
- Press for Change
  http://www.pfc.org.uk
- Beaumont Society
  http://www.beaumontsociety.org.uk
- FTM Network
  http://www.ftm.org.uk
- Gires (Gender Identity Research and Education Society).
  http://www.gires.org.uk

Young people

- Albert Kennedy Trust. LGB youth.
  http://www.akt.org.uk

- Gay Youth UK
  http://www.gayyouth.org.uk
- Mermaids. Trans youth.
  http://www.mermaidsuk.org.uk/

Older people

- Polari
  http://www.casweb.org/polari/
- Age Concern LGBT Project
  http://www.ageconcern.org.uk/AgeConcern/openingdoors.asp

Handout for clients

The following may be useful questions for a client to ask a potential therapist to assess their ability to work in an affirming way with sexual and gender minority clients (adapted from Bettinger, 2001):

- Do you believe that sexual orientation can or should be changed?
- What work have you done to understand your own anti-homosexual bias?
- What specific training have you done to work with sexual or gender minority clients?
- What reading have you done about LGBT psychology/therapy?
- When did you last attend a workshop/seminar on working with sexual or gender minority clients?
- Have you worked with other sexual and gender minority people?

Questions to ask yourself after an initial meeting might be:

- Did you feel a need to hide anything?
- Were you honest?
- Did you need to explain anything about your life to the therapist and how did they receive this? How comfortable were you doing this?
- Do you look forward to talking with the therapist again?

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APPENDIX 1: HOMOWORLD

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You wake up to the sound of your radio alarm dedicating songs to same sex couples:

- Jolene, please don't take my woman;
- When a man loves a man . . .

As you sit to have breakfast you gaze blankly at the cereal packet depicting the bonuses of its vitamins and minerals as played out by a family running through a cornfield: two dads, their son and a red setter. You briefly flick on Breakfast TV to catch the end of Richard and Jimmy discussing the latest face make up available for drag queens.

You leave for work, passing some of your neighbours saying goodbye on the way: Melissa and Iris and further down the street John and Mike. As you sit on the tube you look around you at the ads to pass the time: cheaper travel insurance for same-sex couples, the wonderbra ad: 'Come on girls'. At the next stop a man enters the tube and something about him you can't put your finger on makes you suspect he is also heterosexual. He glances over and spots you and smiles the smile of recognition. You think 'I can tell you're straight too, but maybe no one else here has noticed!'. You might laugh to yourself and enjoy the exclusivity of the contact.

Arriving at work, one of the admin staff is showing pictures of her holiday she just took with her girlfriend in Lesbos. As you join the group to look at the photos you get asked 'Where did you take your last holiday?' Do you admit it was Corfu, a destination well known for its heterosexual holidays, and do you say who you went with?

You start your working day and see your first client. During the session the client discusses her excitement at having found a sperm donor through one of the many agencies set up to match potential parents with similar outlooks on parenting. Can you relate to this and share her joy? She makes the comment: 'you know what it's like, it takes so much thought, time and testing to find the right match. Finally I found someone who wants to be there to talk through decisions but agrees to let me have the final word'. How do you feel admitting to yourself that you don't fundamentally know what its like, that for you it would just be a case of stopping using birth control? The thought rekindles the awkwardness you felt finding one of only two clinics in London set up to provide birth control. The stigma you might have felt walking towards it through the hospital grounds, surely everyone must know that's where the heteros go? The condescending looks of the receptionist as she asks you loudly whether you have used the service before and would you prefer your GP not to be informed. You might find

these thoughts and memories interrupting your session. Do you take this to supervision? Does your supervisor even know that you are straight? Do you know what your supervisor's personal feelings are about it? Do you fear your supervisor might be secretly pathologising you? These thoughts make you remember that you will be changing placements in a few months. You briefly hope the next team will be more accepting.

At the end of the day people are going for a drink at the nearest gay bar on the corner. Some are bringing partners. Do you invite yours, knowing there will be staff there you are not out to? Staff whose response to your heterosexuality you cannot be sure of. Or do you go for a few hours and then leave to travel into central London and the straight ghetto of Old Brompton Street? But maybe you just want a quiet drink as you are tired and you know Old Brompton Street will be full of pumping Celine Dion and boozed pint drinkers. With no real alternative, you decide to head home. Just as you have made the decision your partner texts to say he will meet you at the tube as he is leaving for home now too. As you smile a member of staff you don't know well catches your eye and says, 'That from your girlfriend? What's her name?' Do you come out, lie or say you're much too busy to be in a relationship? You wonder what their response would be if you did come out:

- full acceptance;
- a total lack of interest and changing the subject due to embarrassment;
- or else they might imagine they now have licence to ask you a list of overtly personal questions because 'some their best friends are straight' and they've even been in a straight bar so they really don't have a problem with it, e.g.
  'So how long have you known you were straight?'
  'What a waste, I would never have guessed you were straight.'
  'Do your parents know?'
  'Is the sex better?'
  'What do you actually do in bed anyway?'

Finally you reach your home tube station and as promised your boyfriend is there to meet you. You feel a flood of relief at seeing him, realising how tired you are. But do you greet him with a kiss with all these people still around? As you walk home you both have to walk down a quiet street. You start to hold hands, glad of the contact. However, unexpectedly a group of youths rounds the next corner and you let go. Did they see the contact? Are they going to say anything, heckle you? Worse still, is this a potentially violent situation? You both stare at the floor as you walk past.

Safe behind closed doors at last, you decide to order a pizza. Your partner is in the kitchen when the doorbell rings and doesn't realise you've already opened it. He shouts 'I'll get that darling' and you notice the pizza

delivery boy trying to hide a laugh as your boyfriend bounds into the hall behind you.

As you curl up on the sofa you flick on the TV to see if anything is on. Nothing matches your mood:

- BBC1: the film *When Harry met Henry*.
- BBC2: A review of the contemporary version of *Romeo and Jonathan* at the Young Vic.
- ITV: American funniest home videos special on commitment ceremonies.
- CH 4: *Big Brother*, the episode where the straight person comes out to a fanfare of questions.
- CH 5: *Better Gay Sex*.

You flick through a copy of *The Blue Paper* (the free 'straight' paper about the scene), which you remembered to pick up last time you were in the centre of town as you can't get it locally. You are amused by the rally to join a kiss-in protest after a straight couple were asked to leave the airport lounge following their public display of affection. However, you become disheartened as you read that Clause 29 has once more not been voted out by the House of Commons, their fear being that if straight relationships are even acknowledged to exist by schools it might result in young girls wanting to experiment with older men, or boys with older women. 'This country needs to uphold the same-sex values that made it strong' and are reflected in its tax benefits.

You finally decide to turn in, deciding not to read any more of your Mary Sheldon novel which you bought excitedly because it actually featured a straight character in its subplot. However, you've gone off the book since you found the character was a shallow representation of straight clichés.

The end of another day in Homoworld!

APPENDIX 2: FILMS TO CONSIDER USING IN TRAINING

If These Walls Could Talk 2

Three lesbian stories are shown in different time periods in the same house. The first is set in the early 1960s and shows the devastating impact of the death of a woman whose family do not accept her lesbian relationship, and so the surviving woman is threatened with losing their shared home in addition to her partner. The second story is set in the early 1970s and illustrates the politics of butch/femme dichotomies pertinent to feminism at that time. The final story is a light-hearted modern day yarn of a lesbian couple trying various ways to have a baby.

The Gay Rock and Roll Years

This film shows how lesbians and gays have been represented in films through out the history of cinema. Early footage of lesbians and gay men in distress or being blackmailed because of their sexuality can illustrate how things have changed.

TransAmerica

The film starts with a description of the expensive and complex body modification procedures that male to female transexuals undertake before they have gender reassignment surgery. It demonstrates the need for psychiatric approval to undergo the surgery and how disempowered this can make clients feel. Later in the film a family's response to a transitioning woman is depicted and her difficulty in being accepted in her new gendered identity.

Boys Don't Cry

This film is about a young woman living as a man in mid-country America without access to transsexual communities or surgery. The film shows the hatred that gender variant people can experience from others, which results in extreme violence and murder.

Brokeback Mountain

This film also depicts mid-America but through the experiences of two male cowboys who fall in love. Both men marry to try and live a heterosexual lifestyle but continue to meet regularly at Brokeback Mountain. The film

contains many touching scenes and speeches of the intensity of their feelings for each other within a context that makes it impossible to be together.

But I'm a Cheerleader

This film is about an American high school student whose friends know she is a lesbian before she does. The start of the film has excellent examples of lesbian stereotypes (e.g. being vegetarian) that they confront her with to make their point. The latter part of the film shows a conversion therapy centre.

APPENDIX 3: SEXUAL MINORITY TIMELINE

1. **1935** Freud normalises homosexuality and bisexuality in therapy.
2. **1948** Alfred Kinsey publishes *Sexual Behaviour in the Human Male* and *Sexual Behaviour in the Human Female*, suggesting a continuum between homosexuality and heterosexuality.
3. **1954** In the UK the Home Secretary appoints the Wolfenden Committee and this reports in 1957 and recommends that homosexual acts between consenting adults in private should no longer be illegal based on arguments that the law was impractical rather than not immoral and the age of consent set at 21. Supported by the Archbishop of Canterbury, the British Medical Association and National Association of Probation Officers.
4. **1966** Martin Seligman uses aversion therapy to change sexual orientation.
5. **1967** Sexual Offences Act receives Royal Assent, partially decriminalises sex between men aged over 21 in England and Wales.
6. **1968** Charles Socarides uses psychoanalytic theory to promote reparative therapy.
7. **1969** Stonewall riots start gay rights movement in the USA.
8. **1969** Word 'homophobia' appears in print in American *Time* magazine.
9. **1970** The first meeting of London Gay Liberation Front.
10. **1973** The American Psychiatric Association removes homosexuality from a list of mental disorders.
11. **1979** Michael Foucault writes about anti-essentialist notions of sexual identity suggesting sexuality is socially constructed.
12. **1981** HIV first named and safer sex emerges.
13. **1982** Homosexual orientation decriminalised in Northern Ireland with the passing of a law reform in the House of Commons.
14. **1986** DSM and American Psychiatric Association removes all references to homosexuality as a psychiatric disorder.
15. **1987** In the UK Section 28 of the Local Government Act, preventing the 'promotion of homosexual orientation' by local authorities with help of Local Government Minister Michael Howard.
16. **1989** Stonewall lobbying group established in response to the introduction of Section 28.
17. **1990** Term 'queer theory' first used at a conference in California by Theresa De Laurentis.
18. **1990** Term 'heterosexism' coined by Herek.
19. **1992** Nicolosi, Socarides and Kaufman found National Association for Research and Therapy of Homosexuality.
20. **1992** WHO *ICD* drops classification of homosexuality as a mental disorder.

21 **1994** In the UK the age of consent between two men is reduced from 21 to 18. An amendment to reduce to 16 is defeated in the House of Commons.
22 **1996** *Pink Therapy* published in the UK, by Davies and Neal.
23 **1997** In the UK Government immigration policy recognises same-sex couples under certain conditions.
24 **1998** In the UK the age of consent for sex between two men is reduced to 16 in House of Commons but not Lords.
25 **1998** BPS Division of Counselling Psychology surveys its members' attitudes and practices of working with lesbian and gay clients.
26 **1999** In the UK the Law Lords rule that same-sex partners are entitled to the same tenancy rights as a heterosexual spouse.
27 **2000** The American Psychological Association produces guidelines for psychotherapy with lesbian, gay and bisexual clients.
28 **2000** The Australian Psychological Society produces *Ethical Guidelines for Psychological Practice with Lesbian, Gay and Bisexual Clients.*
29 **2000** In the UK a new code of conduct is introduced by the army following the removal of the ban on lesbian and gay men serving in the armed forces.
30 **2000** The Sexual Offences (Amendment) Act 2000 came into force, reducing the minimum age of consent from 18 to 16 in England and Wales, and making male rape a criminal offence.
31 **2002** *Handbook of Affirmative Psychotherapy* by Ritter and Terndrup published.
32 **2002** In the UK unmarried and gay couples are given the right through Parliament to adopt.
33 **2003** In the UK Section 28 of the Local Government Act is repealed after 15 years.
34 **2003** In the UK Employment Equality (Sexual Orientation) Regulations became law making it illegal to discriminate against lesbians, gay men and bisexuals in the workplace.
35 **2004** In the UK the Civil Partnerships Act receives Royal Assent.
36 **2004** In the UK the Gender Recognition Act provides transgender people with legal recognition in acquired gender, subject to some specified exceptions.
37 **2005** In the UK Section 146 of the Criminal Justice Act 2003 is implemented, empowering courts to impose tougher sentences for offences aggravated or motivated by the victim's sexual orientation.
38 **2005** In the UK the introduction of the Adoption and Children Act gives wide-ranging rights to same-sex couples wishing to adopt a child.
39 **2006** In the UK the Equality Act makes inclusion of LGB staff and user/patients within health and social care a requirement.
40 **2007** The Faculty of HIV/Sexual Health of the Division of Clinical Psychology (DCP) of the BPS write best practice guidance for the

training of clinical psychologists in sex and sexuality and surveys the training course provision.

41 **2007** BPS sets up a working party to develop guidelines for working clinically with sexual minority clients on request of the Faculty of HIV and Sexual Health of the DCP.

42 **2007** *The Yogakarta Principles on the Application of International Human Rights Law in Relation to Sexual Orientation and Gender Identity* is published (International Commission of Jurists & International Services for Human Rights).

43 **2008** Pink Therapy starts a certificate course in sexual minorities therapy.